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SOCIAL SCIENCE RESEARCH

**THE IMPACT OF HIV/AIDS ON  
LOCAL-LEVEL DEMOCRACY:  
A CASE STUDY OF THE ETHEKWINI  
MUNICIPALITY, KWAZULU-NATAL,  
SOUTH AFRICA**

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# **The Impact of HIV/AIDS on Local-Level Democracy: A Case Study of the eThekweni Municipality, KwaZulu-Natal, South Africa**

## **Abstract**

The aim of this paper is to provide a preliminary analysis of how the HIV/AIDS epidemic already does and increasingly will impact on local-level democracy, and to recommend areas for future research and analysis on this topic. Many people have speculated that HIV/AIDS will detrimentally affect democracy and democratic systems of governance, but very little research has been done to support this claim. In an effort to fill this gap, this research examines the impact of HIV/AIDS on one key component of a democratic system: local-level government. Municipalities provide a large proportion of essential basic services, and also represent one of the primary opportunities for public participation and decision-making at a community level. If the epidemic causes municipal governments to falter or fail, the implications for service provision, for public support of democracy, for law and order, and for political stability could be significant.

This paper takes the eThekweni Municipality in KwaZulu-Natal as a case study of the current and potential impact of HIV/AIDS on municipal government and local-level democracy. It examines the impact of HIV/AIDS on the public's demand for services and on the municipality's capacity to govern and provide services, looking specifically at the representative Metro Council and at four service-provision departments. It also reviews the municipality's efforts to respond to HIV/AIDS. Finally, it considers possible avenues for future research, given the hypotheses raised by this exploratory inquiry and the available data. Research was conducted primarily through in-depth interviews with government officials, but also included a review of available literature, analyses of available quantitative data – on the municipality's human resources, the demand for services, and the representative council – and some predictive modelling.

Preliminary findings confirm that the epidemic will present a unique and serious challenge to institutions of local government, but otherwise raise more questions than answers. As communities grapple with the impact of the epidemic and rely increasingly on providers of basic services, the very institutions that provide

these services will themselves face absenteeism, turnover, and financial strain as a result of the epidemic. However, the particular dimensions of the impact on municipal governments are still largely unknown, and more in-depth and comparative research is needed to better understand the nature of the threat to local-level democracy, and to help municipalities adequately plan for and minimise the epidemic's impact.

## Introduction

It is clear that the HIV/AIDS epidemic already does, and increasingly will, impact on every sector of society. Recently, many people have speculated that HIV/AIDS will detrimentally affect democracy and democratic systems of governance, but very little research has been done to support this claim.<sup>1</sup> In an effort to fill this gap, this paper presents the findings of preliminary research on the impact of HIV/AIDS on one key component of a democratic system: local-level government. Local government is one of the primary avenues by which individuals and communities access democratic systems, and by which those systems serve the public. Municipalities provide a large proportion of essential basic services and represent one of the primary opportunities for public participation and decision-making at a community level. If the epidemic causes municipal governments to falter or fail, the implications for service provision, for public support of democracy, for law and order, and for political stability could be significant.

This paper takes the eThekweni Municipality in KwaZulu-Natal, South Africa (which manages Durban, one of the five largest cities in South Africa)<sup>2</sup> as a case study of the current and potential impact of HIV/AIDS on municipal government and local-level democracy. It examines the impact of HIV/AIDS on the municipality's capacity to govern and provide services, on the demand for services, and on municipal-level representative institutions. It also reviews the municipality's efforts to respond to HIV/AIDS and minimise its impacts. The intention is to provide a preliminary analysis of how the epidemic affects one municipality in the hardest-hit province of one of the hardest-hit countries in the

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<sup>1</sup> For a review of some of the work done on this topic, see another paper by this author: "AIDS and Democracy: What Do We Know? A Literature Review," prepared for *AIDS and Democracy: Setting the Research Agenda*, a workshop held in Cape Town, South Africa in April 2002, accessible at <http://www.und.ac.za/und/heard>.

<sup>2</sup> The names eThekweni and Durban are used interchangeably, in both official and unofficial sources, to refer to the recently-amalgamated municipality that includes the Durban central area and a number of surrounding communities. The terms "municipality" and "unicity" are also used interchangeably, and all four terms will be used in this paper.

world, and to recommend areas for more extended research and analysis on this and other municipalities.

## Research Methods

The researcher attempted to compile both quantitative and qualitative data on how the HIV/AIDS epidemic is affecting the eThekweni Municipality. She also aimed to identify any quantitative indicators that could be tracked as part of a more long-term and in-depth research effort on the impact of HIV/AIDS on municipal governments or local-level democracy. The eThekweni research was seen as exploratory, hypothesis-raising research that would provide some of the first actual data on how the epidemic is affecting democracy and governance, given that almost all prior work has been speculative and theoretical in nature. Except for preliminary, background research and the development of a plan of inquiry, this research was conducted in its entirety between August and November 2002. The short time-frame was a significant limitation on the extent of research undertaken.

The research was also limited in temporal scope. A retrospective analysis was essentially impossible to conduct, because the South African local government system was completely restructured in 2000, making most data from prior to 2000 incompatible with any subsequent data. The local government restructuring process included the redrawing of municipal boundaries and, consequently, the creation of new local and district municipalities and the amalgamation of previously-distinct government systems. In eThekweni, an apartheid-era construction of separate municipalities – each with its own local council, governance structures, and service-provision departments – was amalgamated into a new, massive, single entity. Therefore, the research focused on gathering information on the current situation – data that can serve as a baseline for later efforts to track the impact of HIV/AIDS on the municipality – and on some preliminary epidemic impact modelling.

The first phase of research involved a series of interviews with people from different sectors of the eThekweni municipal government, ranging from the health and urban strategy departments to the deputy municipal manager's office.<sup>3</sup> These individuals were identified by means of word-of-mouth recommendations, and the interviews were designed to extract general information about the perceived impact of HIV/AIDS on the municipality, and about the municipality's response to HIV/AIDS. They also served to identify what data was available and what future avenues of inquiry might be most

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<sup>3</sup> See bibliography for list of interview subjects.

productive. A related component of this phase was a detailed search of the eThekweni online official government website for all reports, policies, minutes, and other documents that mention HIV/AIDS, and for general information about the municipal structures and departments.<sup>4</sup>

The research subsequently progressed along two avenues, which explored the impact of the epidemic on the municipality's representative council and on service delivery. First, available data on councillor attendance rates and reasons for absences were collected and analysed. Second, a range of four key service-provision departments were identified, and in-depth interviews with departmental directors, managers, or human resource officers were conducted. Selection of departments proceeded as follows: letters were sent to the head of every major service-provision department, followed by phone calls to set up interviews. Some departments were excluded because department heads did not return phone calls, were on leave, or were very new to the position; likewise, some were included because officials were quick to agree to a meeting. Nonetheless, a deliberate effort was made to include a range of departments which were likely to experience different sorts of impacts. The interview subjects were primarily the departments' top officials, occasionally in addition to – and in one case, replaced by – human resource or programme officers; it was believed that these individuals would be able to offer a broad overview of the impact of HIV/AIDS on the respective departments.

An additional analysis of the impact of HIV/AIDS on public participation was initially considered but subsequently abandoned, because preliminary interviews suggested that there may be no evident impact on participation, and because a method for measuring public participation proved very difficult to construct (Mpho Mtembu and Linda Mbonambi, 2002: interviews).<sup>5</sup> The question of whether and in what way HIV/AIDS will affect democratic participation, including but not solely at a local government level, remains a vital topic for future research.

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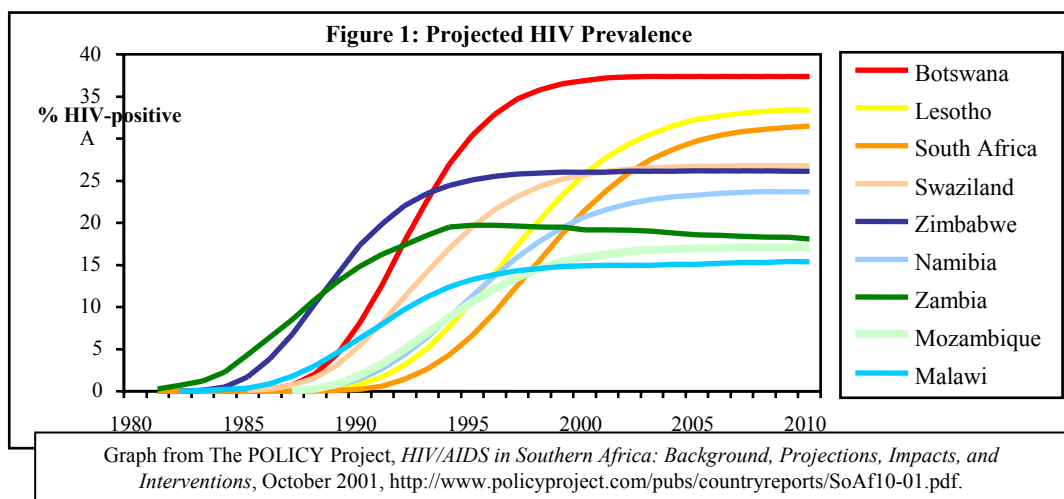
<sup>4</sup> The official eThekweni website is <http://www.durban.gov.za>.

<sup>5</sup> These two officials who are directly involved with community mobilisation felt decisively that HIV/AIDS would not be a barrier to participation, and rather may serve as an opportunity to increase citizen involvement. One cited examples of civil society mobilisation around HIV/AIDS, and suggested that the epidemic may prove to be the impetus for re-mobilising a society that went through a rapid de-mobilisation after 1994.

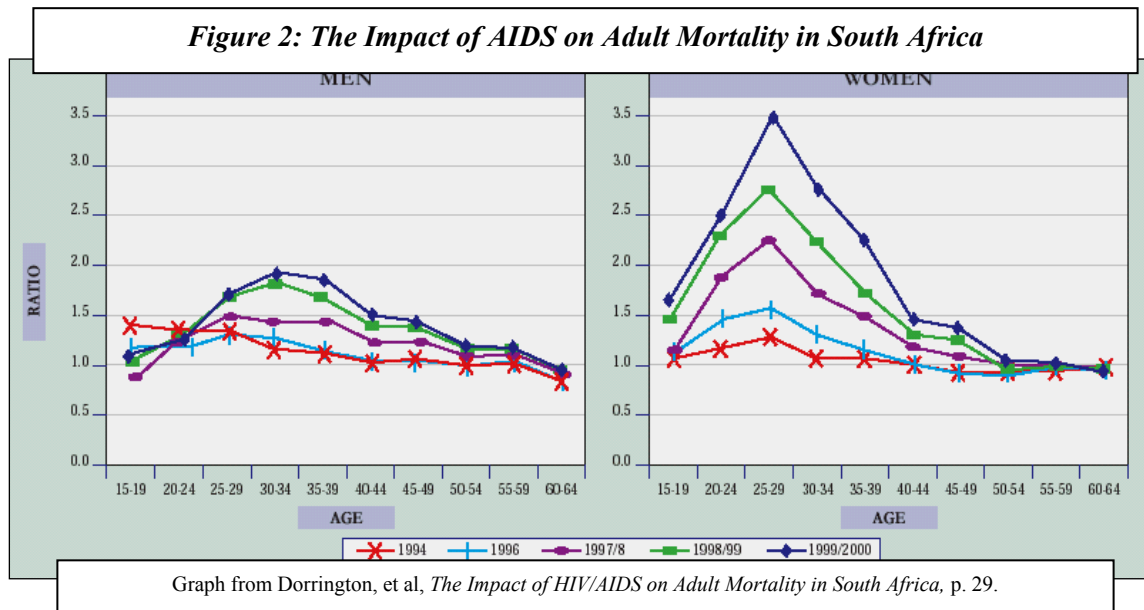


# The HIV/AIDS Epidemic in KwaZulu-Natal, South Africa

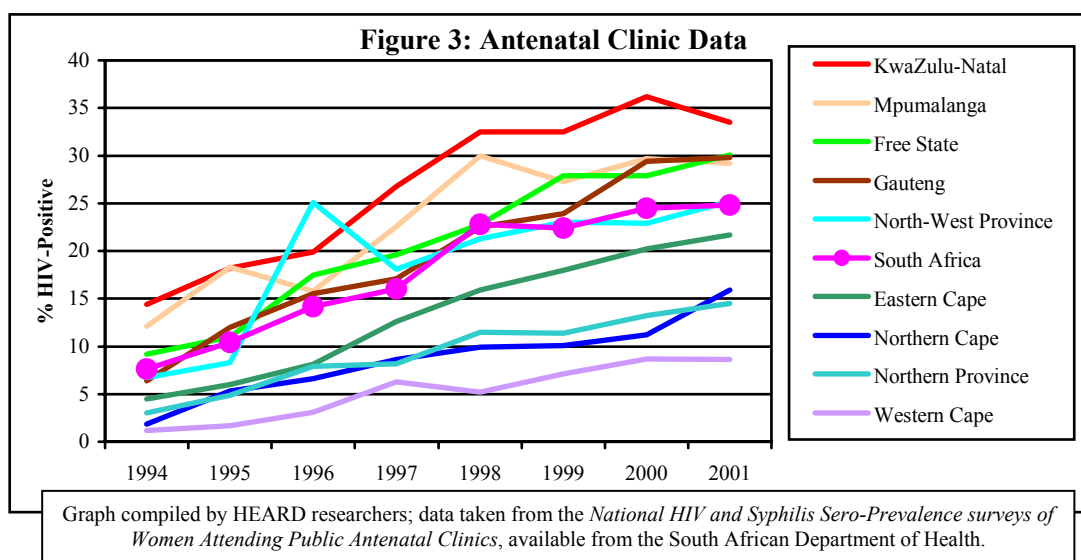
South Africa is one of the countries hardest hit by the HIV/AIDS pandemic, with an estimated 4.74 million South Africans currently infected with the virus (South African Department of Health, 2002). However, as Figure 1 shows, South Africa's HIV/AIDS epidemic is 'younger' than the epidemics in other southern African countries, as well as those elsewhere in the continent. HIV rates did not begin to rise significantly in South Africa until the mid-1990s, when many other countries were already experiencing high levels of AIDS-related illness and death. As a result, the country is just now progressing from an HIV epidemic to concurrent HIV and AIDS epidemics, and has only recently begun to see rising levels of AIDS-related illness and death. In short, South Africa perches at the very tip of the impact of AIDS, and has a long and steep slide to go.



In recent years, levels of AIDS-related mortality in South Africa have begun to rise. A 2001 report by the country's Medical Research Council on the impact of AIDS on adult mortality reported clear evidence that AIDS was increasing mortality rates among young adults, a key economically- and socially-productive age group (Dorrington *et al*, 2002). As Figure 2 illustrates, mortality rates have risen significantly among women between the ages of 15 and 45, with the highest rates of increase among women in their late 20s and early 30s. The increase in men is less dramatic, but still evident.



There is a great deal of geographical variation within South Africa in terms of the severity of the epidemic, with KwaZulu-Natal (KZN) consistently registering as the worst-affected province in the country. This is believed to be the result of a combination of factors, including poverty, migration, social disruption and violence, a high-quality road network, and proximity to the busiest port in southern Africa. KZN had the highest antenatal clinic HIV prevalence in South Africa in 2001, as it has nearly every year since South Africa began monitoring the epidemic, with 33.5% of women attending antenatal clinics in KZN testing HIV-positive, compared to a national average of 24.8% (see Figure 3). The KZN epidemic is also one of the 'oldest' in the country, meaning that many more of the HIV-infected people in that province have developed AIDS.



# HIV/AIDS and Local Government: Ethekewini Municipality

A number of public health experts, political scientists, and assorted researchers have argued that HIV/AIDS will have a detrimental impact on democracy and effective governance.<sup>6</sup> First, there is general consensus that the epidemic will undermine governments' capacity to govern effectively. Governing and service-provision capacity will be reduced because government workforces and elected officials will themselves be infected and affected by HIV/AIDS, causing rising levels of absenteeism and turnover within government institutions. Governments may also face declining revenue bases, thanks to the economic impact of HIV/AIDS and a possible decline in citizen compliance with taxation and rate payment.<sup>7</sup> Moreover, rising demand in heavily-affected sectors, such as health, may begin to drain resources from other areas. As a United Nations General Assembly Roundtable stated, 'HIV/AIDS has a disastrous impact on the capacity of Governments to deliver basic social services. Human resources are lost, public revenues reduced and budgets diverted towards coping with the impact' (United Nations, 2001).

At the same time that the epidemic is undermining the capacity of government institutions, it will also cause a change in the level and nature of demand for government services. Sectors such as health, welfare, and burial services will face rising demand as a result of HIV/AIDS, while a number of other sectors – such as housing and education – may experience a fundamental change in the types of services that are being demanded. One academic has developed the concept of an 'ingenuity gap' to describe this process, whereby diseases like AIDS create an increasing demand for ideas to solve practical, social, and technical problems, but simultaneously reduce the capacity of society to provide good ideas (Homer-Dixon, 2001).

The impact of HIV/AIDS on governing capacity will be felt by every level of government, but will pose a particularly grave threat to local (as opposed to national or regional) government. Local-level institutions already struggle to recruit and retain skilled individuals, the best of whom can find more lucrative and prestigious positions in private and public sector institutions and in higher levels of government. Moreover, local government is often a poor cousin to national government, saddled with a great deal of the responsibility for service

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<sup>6</sup> For a review of some of this literature, see Manning, *AIDS and Democracy: What Do We Know?*.

<sup>7</sup> Robert Mattes, for instance, predicts that HIV/AIDS may reduce citizen compliance. Preliminary ideas by Mattes, discussed in Samantha Willan, *Considering the impact of HIV/AIDS on Democratic Governance and vice versa*, Health Economics and HIV/AIDS Research Division (HEARD), University of Natal, Durban, June 2000, p. 15-16.

provision but provided with relatively little in terms of capacity, resources, or effective institutions. In addition, as mentioned earlier, local government in South Africa has undergone a complete transition in the past few years, with new municipal boundaries, governing structures, and representatives instituted in 2000. Many municipalities are still struggling with consolidating these new structures, and consequently are not prepared to absorb the additional burden of HIV/AIDS.

Another way in which HIV/AIDS may impact on democracy is by reducing public participation. Some analysts have argued that HIV/AIDS will make it more difficult for citizens to participate in democracy, because being ill or coping with the impacts of AIDS – caring for infected loved ones or orphaned children, for instance – will reduce the time and resources available for people to involve themselves in civic life and democratic processes (Mattes, discussed in Willan, 2000: 11). For instance, one researcher has argued that people infected and affected by HIV/AIDS may be prevented from participating in the most central component of democracy: elections. He argues that voter registration requirements will be particularly burdensome for people with AIDS-related illnesses and for their caregivers, who may find it impossible to make necessary trips to complete registration processes and to vote (Youde, 2001). Moreover, limitations on time, resources, and mobility are not the only possible barriers to the participation of people living with HIV/AIDS; the epidemic also might decrease the *motivation* for these individuals, or their caregivers, to get involved with democracy (Willan, 2000: 11). Certainly, the incentives for democratic participation will be different in a context of illness and impending death.

It is also possible, however, that rather than reducing participation, personal experience with AIDS might mobilise some individuals to become more involved in democratic processes, in order to agitate for needed government services or HIV/AIDS programmes. There are many examples of such mobilisation in the South African context, from political advocacy organisations like the Treatment Action Campaign to community-level efforts to provide care and support to those infected and affected by HIV/AIDS.

Another aspect of democracy that may be under threat from HIV/AIDS is government legitimacy and political stability, which may be detrimentally affected by an HIV/AIDS-induced weakening of governing capacity or public participation. A reduction, real or perceived, in the representativeness of elections or the genuineness of democratic participation, for instance, could undermine the legitimacy of a particular government or of democracy itself, particularly if certain groups feel excluded or marginalised. Stigma and blame around HIV/AIDS, moreover, could contribute to inter-group tensions and undermine social and political stability. If governing capacity results in

governments failing to meet the needs and demands of the population, this might also hurt legitimacy and spur dissatisfaction and dissent, and people may be increasingly willing to support any form of government that seems able to deliver services, thereby undermining public support for democracy. A failure to adequately meet the needs of people with HIV/AIDS may be a particular risk. For instance, one analysis of the security implications of HIV/AIDS suggests that if governments are perceived to be poorly addressing AIDS-related issues, the epidemic could 'produce a heightened sense of marginalisation amongst affected populations and a stronger sense of deprivation and resentment towards the government' which may result in spontaneous partisan violence (Fourie and Schonteich, 2001). Another researcher argues that 'in some countries, regime stability may ultimately depend on the credibility and effectiveness of leaders in tackling the multiple crises associated with HIV/AIDS' (de Waal, 2002: 10).

Despite this wide range of hypothesised impacts, there is almost no hard data to substantiate or repudiate these claims. This paper results from a preliminary effort to engage in substantive research on how the epidemic is actually affecting democratic institutions. It focuses on the local-government sector because this is the primary avenue for service delivery and democratic participation for most citizens in South Africa. The research is necessarily limited in scope, and its methods imperfect. However, given the difficulty of isolating and measuring the impact of HIV/AIDS on something as complex and abstract as 'democracy', it seems better to generate some imperfect data than to wait for an opportunity for the perfect data set.

The following are the postulates about HIV/AIDS and democracy that were tested with this research:

- HIV/AIDS will undermine the capacity of local-level democratic institutions, including representative bodies, to govern effectively;
- HIV/AIDS will reduce the capacity of municipal departments to provide services to the public;
- HIV/AIDS will increase and/or change the nature of demand for government services.

Central to these postulates are a number of key concepts. The first is that of *impact*, which is obviously integral to this research and analysis. The impact of HIV/AIDS is the way the epidemic affects an individual, institution, community, society, or some other entity. This impact may be direct, such as when the epidemic imposes additional health care costs on an organisation by infecting its employees. The impact may be more indirect, such as when the demographic consequences of the AIDS epidemic change the shape of society, and thereby

affect the nature of demand for government services. Broadly speaking, when this paper refers to the *impact* of HIV/AIDS on a particular institution of the eThekweni municipality, on the municipality as a whole, or on local governments or local-level democracy, it is referring to a whole range of different ways in which the epidemic and its accompanying demographic, economic, and social consequences may affect those entities directly, or may impose new or more difficult challenges.

Another two important concepts are *susceptibility* and *vulnerability*. Susceptibility refers to ‘those features of an organisation that make it more or less likely that its workers will contract HIV’, and vulnerability refers to ‘those aspects of an organisation that make it more or less likely that unusual levels of illness and/or death will have negative effects on organisational performance’ (Barnett *et al*, n.d.: 15). For instance, a government department that employs a large number of unskilled workers, who have higher rates of HIV infection than higher-skilled groups, has a workforce that is more susceptible to being infected by HIV. A department that relies heavily on the knowledge and experience of certain key individuals is more vulnerable to the impact of illness and death among those workers.

For this effort to uncover the impact of HIV/AIDS on the eThekweni Municipality, the concepts of impact, susceptibility, and vulnerability were operationalised into a number of variables. The research looked at two types of impact: the impact on the *capacity* of the municipal institution: its ability to govern effectively and/or to provide services to the public; and the impact on the public’s *demand* for services. Impact on capacity was understood to involve both the institution’s susceptibility and its vulnerability. An estimation of the level of susceptibility was based on the characteristics of the particular workforce under consideration; in addition, information was collected on the managers’ perceptions of how HIV/AIDS was affecting their workforce, as well as any perceived and/or measured changes in illness, absenteeism, and deaths. The overall level of vulnerability was estimated based on interview questions about levels of training and expertise among employees, the ease of recruiting replacement employees, and the effects of absenteeism, illness, or turnover on productivity and operations, among other things. In addition, managers were asked for their opinions of how HIV/AIDS had affected their department’s governing or service provision capacity, through its impact on personnel or through another type of impact on operations.

The impact of HIV/AIDS on demand was found to be of two types: first, an impact on the level of demand (usually an increase); and second, an impact on the nature, or type of demand. In addition, these possible impacts on demand had consequences for accurate and effective planning for the medium and long

term. The demand-side impacts of HIV/AIDS were operationalised into four variables: the managers' perceived impact on the level of demand; their perceived impact on the nature of demand; the actual (measured) change in demand; and the managers' perceived impact on strategic planning.

An effort was also made to rank the overall impact of HIV/AIDS on the department as 'high', 'medium', or 'low', taking into account all the available information. Although these rankings are based primarily on the managers' own perceptions of overall impact, along with any available data and general information about the epidemic, the actual designation of impact was made by the researcher and is, necessarily, subjective.

Finally, the research explored any responses to HIV/AIDS by the different departments and by the municipality as a whole, and ranked the quality of those responses. Again, this ranking was subjective.

These variables were applied to the six 'cases' examined within the eThekweni Municipality: the municipality as a whole, the representative Metro Council, and the departments of Cemeteries and Crematoria, Housing, Fire and Emergency Services, and Electricity. The findings are summarised Chart 1, and are discussed in greater detail thereafter.

## **Governing Capacity**

The most direct impact of HIV/AIDS on governing capacity will be through infected and affected government employees. Evidence suggests that AIDS already does – and increasingly will – directly and significantly affect the South African civil service at a national level. A report commissioned by the government and leaked to the press, though never officially released, found that AIDS would be the leading cause of death among public servants by 2002 (Business Day: 2001). According to a newspaper account, the report predicts between 11 000 and 13 000 new HIV infections among public servants throughout South Africa in 2002, and estimates that between 228 000 and 253 000 public servants nationally will have died of AIDS by 2012 (*ibid.*). To put these numbers in context, the South African public service employs approximately 1.1 million people (Grant *et al*, 2002: 16). In addition, the report predicts that the epidemic will impose serious costs as a result of AIDS-related absenteeism and reduced productivity (Business Day, 2001).

At a local level, eThekweni municipal managers report that they have experienced an impact from HIV/AIDS on their workforces. The municipality's Director of Corporate Services said there has been a definite impact throughout

the municipality, from top to bottom and laterally across every sector and every department (Sipho Cele, 2002: interview). The Deputy Municipal Manager also affirmed an impact on the workforce ‘across the spectrum’, including extended illness and death among members of the representative eThekweni Municipal Council (S’bu Sithole, 2002: interview). In the department of Parks, Recreation and Culture, the most recent human resource data showed a large increase in the proportion of staff turnover that was caused by medical problems, to 32% of total turnover for a six-month period (Pam Matthias, 2002: interview). Finally, in the health department, the deputy director said they had lost employees and members of employees’ families to the disease. She noted, in particular, the impact on nursing staff, who were facing ‘multiple layers of loss’, as well as the frustration of not being able to do anything for their patients with AIDS (Lynn Wild, 2002: interview).

The loss of personnel to HIV/AIDS is particularly problematic given the city’s difficulty in recruiting and retaining skilled individuals. As one individual from the city’s transformation office said, the municipality is competing with the private sector, other levels of government, and civil society for skilled, quality personnel. It also struggles to compete with Johannesburg, Cape Town, and international locations. If the city starts losing people in key, strategic positions to AIDS, he said, it will be a serious blow to its operations, because it will be difficult to find replacements of a similar calibre (Mbonambi, 2002: interview).

Another important impact on governing capacity is the effect of HIV/AIDS on *representative institutions*, which also has implications for the depth and genuineness of local-level democracy. High levels of absenteeism could undermine the representativeness of the metro council, even robbing some wards (or party constituencies) of their representation in this governing body. Both absenteeism and turnover also represent a reduction in available skills and a loss of experience and training. Moreover, councillors who are elected by wards must be replaced through by-elections, which have a significant economic cost and are likely to have a lower turnout than regular elections, thereby limiting the electoral mandate of those newly-elected individuals. In eThekweni, according to the deputy municipal manager, there have been some recent instances of extended illness and death among the city’s 200 councillors (Sithole, 2002: interview). In order to expand upon this report, an analysis of councillor attendance records was conducted in order to explore whether HIV/AIDS was having a more widespread impact on absenteeism and illness.

This preliminary analysis, based on the minutes from meetings of the eThekweni Metropolitan Council, provides a rough idea of the current levels of absenteeism and some tentative evidence of trends over time. There were two types of data available: the applications for leave submitted at each meeting of the council,



and the attendance record for each meeting, with any reasons given for the leave application or absence.<sup>8</sup> These two sources of data tend to mirror one another to a large extent, because absences without applications for leave are officially prohibited, and two unexplained absences are grounds for dismissal from the council (Beverley Steele, 2002: interview).<sup>9</sup> Minutes are available for the almost-monthly meetings from February 2001 to October 2002; however, no reasons were recorded for leave applications prior to the July 2001 meeting.<sup>10</sup> Absences are recorded as being for Municipal Business, Indisposition (i.e., illness),<sup>11</sup> or general (personal) Leave; in some cases, no reason is given. Applications for leave are either recorded with no reason (presumably personal leave) or for Indisposition or Municipal Business.

Analysis of this data is necessarily limited by the short time frame available, and by some uncertainties in the data. For instance, it is possible that some of the applications for sick ('indisposition') leave were not recorded as such in the minutes, or that some of the absences recorded with no reason were actually the result of illness. Another source of uncertainty is the possibility that councillors' behaviour could have changed during this period for some reason, with councillors becoming more or less likely to take leave, or to cite indisposition as the reason for leave, and hence confounding the data. The uncertainty is minimised somewhat by the fact that the same individual was responsible for recording the council's minutes – including attendance and the applications for leave – during this entire period (and for ten years' prior), and that the policies on councillor leave and absenteeism have not changed during this period, and in fact follow a 1974 ordinance (Steele, 2002: interview).

Despite these limitations, this analysis does provide some preliminary information, and more importantly, a baseline for future monitoring and analysis.<sup>12</sup> The data (aggregated into three-month averages) shows no particular trend in the total number of councillors who are absent for a meeting, and

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<sup>8</sup> Council minutes were downloaded from <http://www.durban.gov.za/council/index.htm>. For a tabulation of the number of applications for leave and number of absences per meeting, and the number for reason of indisposition, see Appendix C.

<sup>9</sup> Steele has been responsible for taking minutes at council meetings for the last 12 years.

<sup>10</sup> It would probably be possible to access minutes from pre-2001 meetings from a paper-based archive. However, the usefulness of any comparisons with earlier years would be highly limited, given the institution as of 2001 of an entirely different council, representing a range of communities previously excluded from the Durban Metro. Prior to that, the area that now makes up the eThekweni municipality was governed by a series of independent local councils.

<sup>11</sup> "Indisposition" is one of the options available to councillors applying for leave, and it is used to request leave due to illness. In other words, those marked "indisposed" are on sick leave. (Phone conversation with Tracy Palm, eThekweni Municipality, August 30, 2002; confirmed in phone conversation with Steele.)

<sup>12</sup> Note that throughout this analysis, the data available for leave applications is from a shorter period than those for absenteeism, with the former beginning in July 2001 and the latter in February 2001.

**Chart 1: The Impact of HIV/AIDS on the eThekweni Municipality**

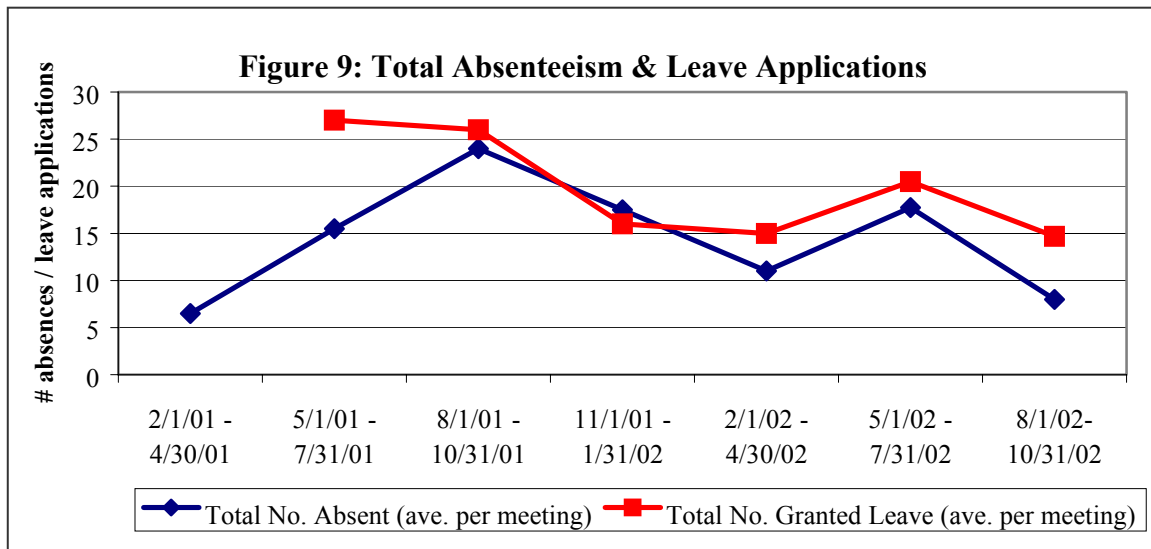
Municipality (overall)						Fire & Emergency Svcs	Housing	Cemeteries & Crematoria	Electricity
Variables	Metro Council								
Mngrs' perceived overall impact	Medium to high	N/A	High to very high	Medium	High	Medium to high			
Susceptibility	Varies	Varies	High; recent instances of ill health retirement/death; told by occupat'l health dept that their staff was highly affected	Low; few workers, mostly high-skill, sub-contract construction labour	High; mostly young, single men, with risk-taking ethos; however, physical req'ts at hiring may exclude some with HIV/AIDS	High; many low-skilled workers			
	High, and extends throughout municipality; Nationally, AIDS leading cause of death of civil servants by 2002	Have been recent instances of extended illness and death among cllrs	High; recent instances of ill health retirement/death; told by occupat'l health dept that their staff was highly affected	None	Medium; have had HIV-positive members, some dying of AIDS, and others taking leave for funerals	High; impacts from turnover, illness on productivity; also on morale of human resources staff			
	Yes; in one dept, illness now cause of 32% of turnover	Yes; data analysis shows upward trend in number of absences/leave applications for reason of illness, and in proportion of absenteeism that is because of illness	Unknown (confounded by policy shift on enforcing attendance rules)	No	Yes	Yes; see substantial increase; many deaths/medical boardings, also many not boarded but are too ill to do jobs			
Vulnerability	Yes	Unknown	Unknown	No	Yes; chief estimated 4 or 5 died of AIDS in last 18 months (out of 1039 total staff)	Doubling of deaths over past 2 yrs; now 4-5 deaths in service per month, plus 1-2 per month medically boarded (out of 1900 total staff)			
	Medium to high; already face difficulty in recruiting/retaining skilled indivs	Unknown; possible impacts: loss of skills/experience, less effective gov'ce, cost of bye-elections, less representative, change balance of power	Medium; provide in-house training of new staff, so turnover is costly; must provide prompt svce	High; workforce highly skilled/experienced, so loss of indivs would have big impact	Very high; severely short-staffed; v. few light duty jobs for ill members; training time limits speed of staff replacement; need years to gain experience	Medium; productivity loss; work physically demanding, and v. few light duty positions; loss of skills/training			
	Varies, but do see impact	N/A	Medium	High; problems with housing delivery: intended title-holders die, leads to problems with transferring ownership to children/others	High; overall lack of experience problematic; short-staffing makes everyone's job harder	Unknown			

Capacity: Governing / Service-Provision

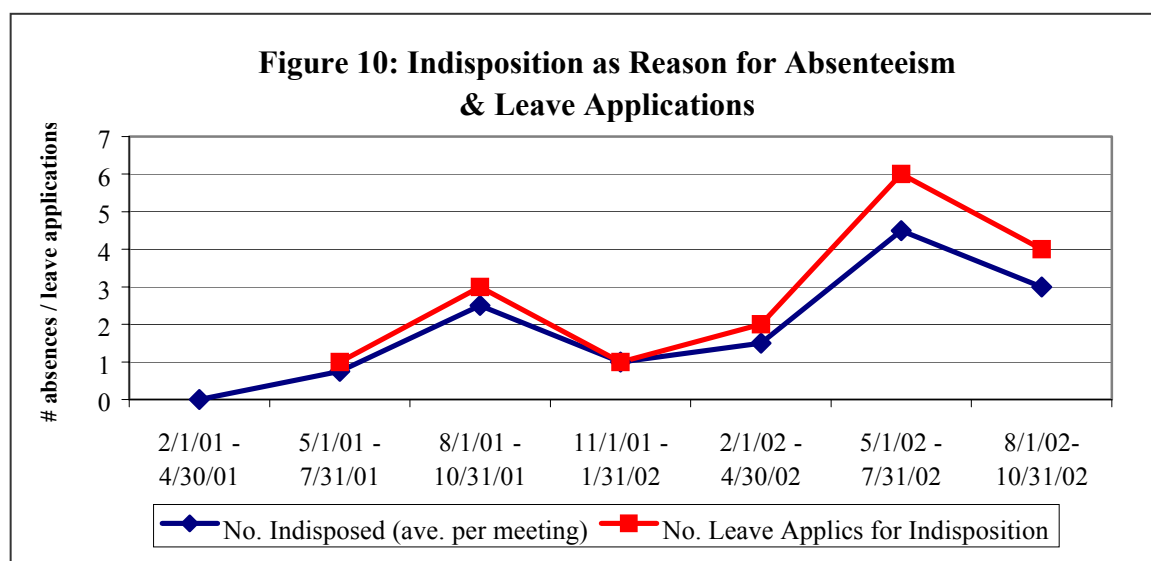
**Chart 1: The Impact of HIV/AIDS on the eThekweni Municipality, cont.**

	Municipality (overall)	Metro Council	Cemeteries & Crematoria	Housing	Fire & Emergency Svcs	Electricity
<b>Variables</b>						
Mngrs' perceived impact on level of demand	Varies	N/A	High	Unknown; depends on household formation and migration	None	None
Mngrs' perceived impact on nature of demand	Varies	N/A	None	High; must provide housing for orphans, child-headed households, and ill/disabled	None	None
<b>Demand for Services</b>						
Actual change in demand	Unknown	N/A	2001-2002 stats show possible AIDS impact: more young adults buried than any other age group; projections show steady rise in demand in future years	Unknown	Unknown	Unknown
Mngrs' perceived impact on planning	High; very little metro-level info about epidemic; must rely on flawed projections for planning services, etc.	N/A	High; complicates planning for burial/cremation demand, and for cemetery land	High to very high; know little about how AIDS affects household formation, so or urban-rural migration, so cannot plan accurately for future demand	None	None
<b>Response</b>						
Quality of response	Poor	Poor	Fair	Very good	Fair	Very good
Nature of response	Haphazard and limited; some positive action by indiv depts; launch in Nov. 2002 of eThekweni AIDS Council a step in right direction	See municipal-wide response	Have begun encouraging employees to discover and manage HIV status; participate in regular AIDS forums	Working on innovative pilot projects for housing orphans, though not nearly enough to meet future demand	Working hard to meet staffing backlog and manage municipal amalgamation; attempts to provide light-duty jobs for ill workers	Comprehensive employee-support prog. provides counselling/referral for any personal issues; have trained counsellors, social workers, and welfare officers on staff; some in-house AIDS education

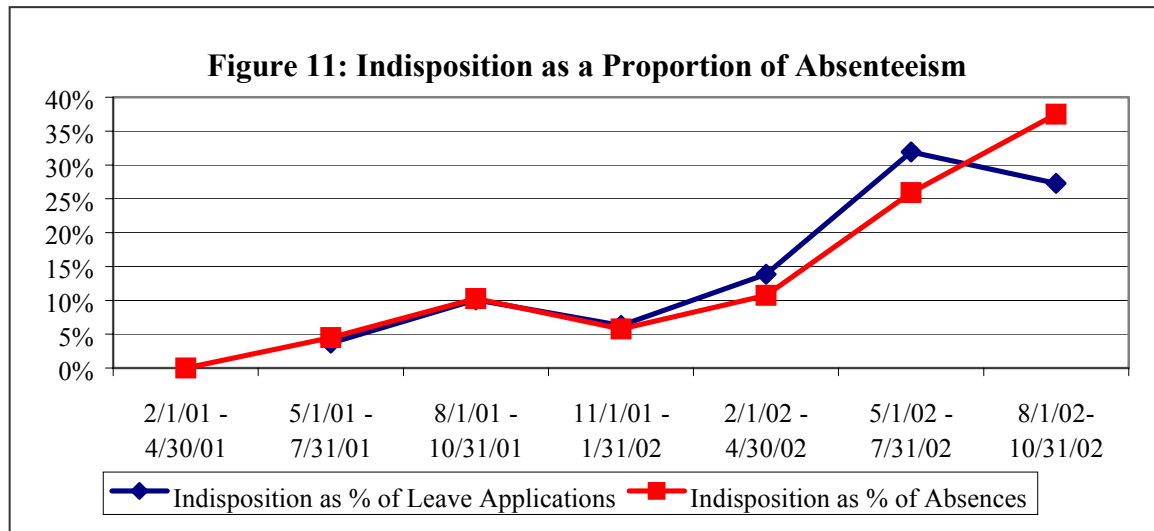
a possible *downward* trend in the total number who request leave (for any reason, including illness). (See Figure 9) This is somewhat surprising, because we would expect HIV/AIDS to cause an increase in the number of absences over time.



The data does suggest an impact of HIV/AIDS in other ways, however. There seems to be an upward trend over the 21-month period in the number of people absent from meetings for reason of indisposition and in the number of applications for indisposition leave (see Figure 10). Although total absenteeism is not increasing, it seems that more of the councillors are missing meetings because they are sick.



The strongest evidence of an impact from HIV/AIDS on councillor absenteeism is a significant and consistent increase in the *proportion* of total absences that was attributed to indisposition, and the proportion of total applications for leave that was for reason of indisposition (see Figure 11). Although the timeline is still quite short, the data does show a very clear upward trend in this proportion.



If these trends are accurate, they show that a growing proportion of councillor absences are the result of illness, and that the absolute number of ill-health absences is growing. This certainly is suggestive of an AIDS-related impact on the council. In order to further test this hypothesis, however, it would be helpful to compare this data on councillor attendance with data from a municipality with a lower incidence of HIV/AIDS, such as Cape Town. This would help determine whether the absenteeism patterns seen here are the result of HIV/AIDS or are caused by something else entirely. Also interesting would be a comparison of the attendance records of councillors who are known to have died of an extended illness with those of healthy councillors, in order to better understand the impact of illness on councillor attendance.

It is also necessary to explore in a more substantive manner the implications of increased councillor absenteeism and turnover for governing capacity and democracy. On the one hand, if the council is accustomed to high turnover among councillors, and if parties are able to replace councillors when necessary from a 'party list', then perhaps the substantive impact is minimal. On the other hand, the loss of experience and training associated with turnover may have a significant impact on the council's operations. Similarly, if councillors remain in their positions but are unable to fulfil their duties effectively as a result of extended illness, this too would have negative implications for the quality of representation and for the council's overall efficiency and effectiveness.

Moreover, if one party is more heavily-affected by HIV/AIDS than other parties – as many believe to be the case in KwaZulu-Natal, where the African National Congress's predominately young, urban, and black constituency is likely to be more heavily-affected by HIV/AIDS than the Inkatha Freedom Party's older, more rural constituency – then the quality of representation for that party's constituency may suffer, and the balance of power may change. Finally, as mentioned earlier, the replacement of ward councillors through by-elections will have economic costs as well as implications for the representatives' democratic mandate.

## **Service Provision Capacity**

The provision of key basic services is in many ways the most important function of local governments, and the effect of HIV/AIDS on the capacity of governments to deliver services is potentially substantial. This research examined the impact of HIV/AIDS on service-provision capacity in the departments of cemeteries and crematoria, housing, fire and emergency services, and electricity. All four departments are already experiencing some impacts from HIV/AIDS – impacts that will only worsen in the coming years – but their nature and degree vary greatly from one department to another.

HIV/AIDS affects the ability of the department of cemeteries and crematoria (Royal Phumlani Ntombela; Jabulani Rome Mdiniso; Pepe Dass, 2002: interview)<sup>13</sup> to effectively supply needed services because the department's employees are infected and affected by the virus. The department has a total of 213 staff, the vast majority of whom are relatively low-skilled (177 of 213 employees are grave diggers or general workers). This means that the department's workforce is likely to be very susceptible to HIV infection. Indeed, the department's managers say that they were told by the occupational health department that their employees are badly affected by HIV/AIDS. A recent policy change that imposed tighter control over employee attendance resulted in lower absenteeism rates; thus, it is not possible to track any impact from HIV/AIDS. However, the department's managers note that they do have employees who are frequently sick, and that they have lost a number of people in recent years to ill health retirement or death. It is perfectly logical to assume that some of these fatal illnesses were the result of AIDS, although it is impossible to know for certain.

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<sup>13</sup> Unless otherwise noted, all information on the Department of Cemeteries and Crematoria is based on the interview with these three people.

The cemeteries and crematoria department is also somewhat vulnerable to the impact of employee absenteeism and turnover, because all employees receive in-house training from the department. This training is designed to ensure that workers understand the by-laws that govern burials and cremations – such as the importance of digging graves to a certain depth, and of carefully marking and recording the location of graves – and that they have appropriate inter-personal skills for dealing with grieving family members. Thus, employee turnover imposes a significant cost on the department, which must not only recruit but also train replacement workers. The department is also vulnerable to the impact of excessive absenteeism, because it must provide a timely service even if certain key staff are missing; as the Director Royal Ntombela said, ‘We are a service provider that cannot postpone our service provision’.

The department of housing (Bedford, 2002; Maurice Makhathini, 2002; Mark Byerley, 2002: interviews)<sup>14</sup> which has a relatively small staff (54) and uses contractors for most of its actual construction work, does not seem to have experienced any impact from HIV/AIDS on its personnel. Because its employees are mostly highly-skilled and experienced, the housing department is probably much less susceptible to HIV/AIDS than a department with a large, low-skilled workforce, but it is also much more vulnerable. Any one individual would be difficult to replace, and thus department’s operations would be quite vulnerable to any losses.

The housing department also faces a number of AIDS-related obstacles to delivering houses. In particular, the department frequently loses clients in the few years between when they register for the housing subsidy and when they receive the title to their home. The director estimated that of every 100 deeds that are conveyed to his office for awarding to clients, 20 of these are in the name of individuals who have since died or otherwise disappeared.<sup>15</sup> In some of these cases, the family members have scattered and the household essentially no longer exists; in other cases, the family members may still be living in the house, but now cannot easily access the deed. Also, it is impossible for people to make provision for transferring their house and land to children or other family

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<sup>14</sup> Unless otherwise noted, all information on the Department of Housing is based on interviews with these people. There also have been two large reports done at a national level on the impact of HIV/AIDS on the demand for and supply of low-cost housing in South Africa: *The Impact of HIV/AIDS on the Demand for Low-Cost Housing*, by Kayamandi Development Services (Pty) Ltd, and *Economic Impact of HIV/AIDS on The Construction Sector and Implications for Housing Policy*, Prepared by Development Works, both available from the Joint Centre for Political and Economic Studies. Unfortunately, these reports were not accessed in time for inclusion in this report, but they are an important resource for any future enquiries into this topic.

<sup>15</sup> This value seems quite high, and probably is due in part to causes other than HIV/AIDS, but the impoverished, informal settlements targeted by the housing department are certainly among the communities hardest-hit by the HIV/AIDS epidemic. In any case, the epidemic is likely to only exacerbate this already substantial problem over the coming years.

members until they actually have the legal title deed, even if they are living at the site and just waiting for the bureaucratic process to run its course; this sometimes results in battles by family members after that person has passed away. Cases like these are a logistical nightmare, and an impediment to effective, efficient delivery of housing.

The department of fire and emergency services (D.M. te Water, 2002: interview)<sup>16</sup> is perhaps a worst-case scenario about the potential for the epidemic to affect a department's capacity to effectively provide services. To some extent, the pre-employment medical examination and physical fitness requirements may serve to lessen the number of HIV-positive individuals who are employed by the department; although HIV infection alone is not grounds for rejection, people whose bodies have been weakened by the virus may not meet the requirements, and other people may choose not to apply to the department because they suspect they are HIV-positive and believe they will be excluded. This does not, however, affect those individuals who are HIV-positive and otherwise healthy – the majority of people living with HIV – and does not prevent individuals from becoming infected once they are employed by the department. Moreover, the department's workforce, composed predominately of young, single men, is highly susceptible to HIV infections. The high level of personal risk involved in a fire fighting career, and the possible 'risk-taking ethos' of fire fighting personnel, may also correlate with risky sexual behaviour and, consequently, higher rates of HIV infection. (A similar risk-taking dynamic is believed to contribute to the high levels of HIV infection among military personnel.)

Already extremely short-staffed – as a result of historic inequities and the recent amalgamation of municipal services, among other things – the department is highly vulnerable to rising levels of illness and absenteeism as a result of HIV/AIDS. Because the workload of fire fighters – who represent 760 out of 1039 positions in the department, or 864 including division, station, and regional commanders – is extremely physically demanding, ill employees are generally unable to fulfil their duties. The department tries to move sick or weak personnel into light duty positions, but there are only a handful of these jobs available that do not require specialised training or experience. Moreover, when someone is forced to go off-duty temporarily because of ill health, it has a significant impact on the department's other personnel, as already short-staffed units are forced to cover for another vacancy.

The department is also highly vulnerable to the impacts of losing employees. In the absence of HIV/AIDS, the department was accustomed to relatively low

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<sup>16</sup> Unless otherwise noted, all information on the Department of Fire and Emergency Services is based on this interview.



levels of turnover among young personnel, although it does lose a fair number to early retirement. It has no problem with recruiting new fire fighters – it hires people with no previous experience or training, and the chief fire officer estimates they get 10 000 applicants each time they advertise – but the process of developing necessary skills takes extensive time and resources. All new recruits go through a three-month basic training programme, which is itself a challenge for the department to administer, because the training section is severely understaffed (it should have 12 trainers, but has only 2) and consequently must pull experienced fire fighters off active duty to help out. However, this formal training is just the first phase of the training process; it takes years to build a good fire fighter with enough practical experience to take a leadership role in the department and to pass on knowledge to the younger members, and much of that training takes place on the job or through informal instruction by the more-experienced fire fighters. Moreover, with 505 vacancies on a total staff complement of 1039, the department has a serious backlog of hiring and training, and is only able to put 40 new people at a time through the three-month training programme. Thus, AIDS-related turnover adds yet another hurdle to an already tremendous challenge.

Finally, the department has a number of critical posts, the loss of which would have a particularly strong impact on its operations. These include the one individual who serves as both manager and technical officer in the communications centre, as well as the operations manager for emergency systems and the mechanics. Any and all management posts are also critical, given the overall youth and lack of experience of the department; consequently, the loss of any managers, whether to illness or retirement or resignation, has a ripple effect on the department.

The department has already begun to experience some HIV/AIDS-related illness, absenteeism, and turnover. It has had to grapple with employees who are afflicted with cycles of illness and health, a common pattern for people living with HIV/AIDS. In addition, the chief estimated that they had seen four or five staff members (out of approximately 500) die in the past 18 months from what he suspected was AIDS-related illnesses. This is lower than the rates seen in some other departments, notably electricity (see below), but is still a significant drain on the department.<sup>17</sup> Moreover, in the absence of comprehensive HIV/AIDS treatment, this number is likely to increase in future months and years. Absenteeism on the grounds of ‘family responsibility leave’

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<sup>17</sup> The rates of AIDS-related illness and death may be lower in this department because of the high physical requirements for employment. As mentioned earlier, some people weakened by the virus or ill with opportunistic infections may be unable to meet the physical fitness requirements or to pass the medical examination. In addition, those who suspect they are HIV-positive may exclude themselves from seeking employment because they believe they will be excluded on medical grounds.

is also increasing, as staff members take time off for funerals. In some cases staff exhaust their ‘family responsibility leave’ on this basis.

In short, the operational effectiveness of the department of fire and emergency services is in danger of being significantly hobbled by the effects of the HIV/AIDS epidemic. Without a large-scale, concerted effort to address the existing issues of short-staffing, and to manage the additional impact of HIV/AIDS, the department’s ability to provide these vital, life-saving services will be affected.

From a human resource perspective, the department of electricity (Ray Sharp, 2002: interview).<sup>18</sup> too has been affected by HIV/AIDS. In recent years out of a staff complement of approximately 1900, the department has had an estimated four to five employees *per month* die in service, with an additional two employees per month being medically boarded. According to the human resource officers’ estimates, there has been a doubling of deaths in service over the past two years, with comparative figures from prior years closer to 1 to 2 deaths and one medical boarding per month. Although these deaths and illnesses are not all due to HIV/AIDS, it is likely that the epidemic is responsible for much of the recent increase. The epidemic has also reduced the department’s productivity. There are a significant number of workers who are too ill to fulfil their normal duties, but not ill enough to be medically boarded, which has a substantial impact on the department’s operations. The bulk of the department’s workers do relatively heavy, manual work that is difficult for bodies that are weakened by HIV/AIDS. The human resource staff and the individuals’ managers work together to try to find light duty alternatives for ill or weakened workers, but such positions are limited in number.

The impact of AIDS-related illness and deaths on the morale of the human resource staff is another indication of the implications of HIV/AIDS for the electricity department. HR staff members spoke of leaving work on Friday in the midst of processing an application for medical boarding, only to find on Monday that the person had died. They say it is frightening to see so many young workers, many with little children, who are sick and dying, since they themselves are mostly quite young. The epidemic is putting an increasingly heavy burden on these, and other, employees, with possible implications for their productivity and long-term well-being.

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<sup>18</sup> Unless otherwise noted, all information on the Electricity Department is based on this interview with Ray Sharp, and eleven members of his staff, on November 18, 2002.

## Demand and Strategic Planning

HIV/AIDS can also affect the public's demand for services – potentially changing both the level and the nature of demand – and, consequently, hinder effective strategic planning. This, in turn, can downgrade the city's governing and service-provision capacity in the medium- to long-term. Several officials voiced concern that without an accurate understanding of how the HIV/AIDS epidemic in Durban would progress and what its impact would be, the municipality would be hard-pressed to plan appropriate municipal services into the future. In fact, the municipality is operating with very limited municipal-level information about the epidemic, because statistics are based primarily on the government's national antenatal clinic survey, and cannot be broken down to a local level. Currently, most of the city's departments rely for planning purposes upon a demographic projection done by the municipality's transport department in 1999/2000 (Traffic and Transportation Department and Durban Metropolitan Transport Advisory Board, 2000; Laura Bedford, 2002: interview). The department should be commended for its foresight in producing such a report, and in explicitly addressing the demographic implications of HIV/AIDS, but the report itself has a number of limitations.<sup>19</sup> First, the data is now outdated, as epidemiological projections based on 1999 data are significantly different from more recent projections. Second, the projections make no allowances for changes in migration patterns, citing the difficulty of predicting such trends. It is true that trends in migration are very difficult to predict, but such trends also have a very significant impact on municipal-level population statistics.<sup>20</sup> Third, the report extends its demographic predictions through to 2020, but any HIV/AIDS projections that far into the future are highly unreliable. In short, the use of this document for city-wide planning around HIV/AIDS is certainly better than *not* planning around HIV/AIDS, and is probably a reasonable planning tool for the near future, but is highly problematic in the medium- to long-term.

Overall, HIV/AIDS has the potential to derail careful strategic planning, even when an attempt is made to take the epidemic into account. As the eThekweni corporate services director noted, if the epidemic affects population growth or otherwise changes demographics in some significant way – by prompting populations to relocate, for instance, and changing the population densities of

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<sup>19</sup> Thanks to Chris Desmond of HEARD for his help in evaluating these demographic projections.

<sup>20</sup> Perhaps in-migration to the city will increase as AIDS kills workers and opens job opportunities; in this case, the population growth figures predicted by the report's "Middle AIDS Scenario" are far too low. Alternatively, perhaps people will react to rising levels of illness and death by returning to the rural areas in large numbers; in this case, the population figures may be an overestimate. In any case, migration is an important factor to take into account.

different areas – the city may invest now in services that prove to be under-utilised, or may under-invest in certain areas (Cele, 2002: interview).

At a departmental level, the impact of HIV/AIDS on the public's demand for services, and the implications for strategic planning, is even more evident. In the department of cemeteries and crematoria, for instance, rising levels of AIDS-related illness and death within the municipality will almost inevitably result in a higher demand for the department's services.<sup>21</sup> The department already faces a severe shortage of burial space, and has even embarked on a campaign to encourage families to opt for cremation instead of burial (Ntombela; Mdiniso; and Dass, 2002: interview).<sup>22</sup> Such change, however, is likely to be highly incremental. In the absence of a substantial behavioural or demographic change, the department estimates it will need 140 hectares of burial space over the next 10 years if death rates remain constant, and 220 hectares if death rates increase by 10% annually. The director says they expect to run out of space in the current cemeteries within 10 years' time and perhaps significantly sooner (Ntombela, 2002: interview).

The department's burial statistics for 2001 and 2002 already suggest a possible impact from HIV/AIDS, although this conclusion is uncertain and is confounded by a number of factors. The burial statistics show that more people in the 26-40 year-old age group were buried or cremated city-wide in 2001-2002 than any other age group except those older than 51 (see chart below).<sup>23</sup>

<i><b>Total Number Buried or Cremated in Durban in 2001-2002</b></i>					
<b>AGE</b>	<b><u>0-12</u></b>	<b><u>13-25</u></b>	<b><u>26-40</u></b>	<b><u>41-50</u></b>	<b><u>51 &amp; Over</u></b>
<b>Males</b>	1172	773	1496	1067	2433
<b>Females</b>	991	698	1307	735	2343

This certainly is an abnormal death distribution; normally, death rates are lowest in the centre of an age distribution and increase toward either end, to a relatively low level among infants and a much higher level among the elderly. Such an abnormality could be indicative of an AIDS-related impact on mortality. However, there are also a number of other factors that could explain this

<sup>21</sup> Theoretically, the demand could remain constant (or even fall) if people dying from AIDS are significantly more likely than people who die from other causes to return to rural areas to die, and/or choose to be buried there. However, this is highly unlikely.

<sup>22</sup> Unless otherwise noted, all information on the Department of Cemeteries and Crematoria is based on this interview.

<sup>23</sup> Statistics obtained from Ntombela, in a document entitled "Cemetery & Crematoria: Burial Statistics for 2001 & 2002."

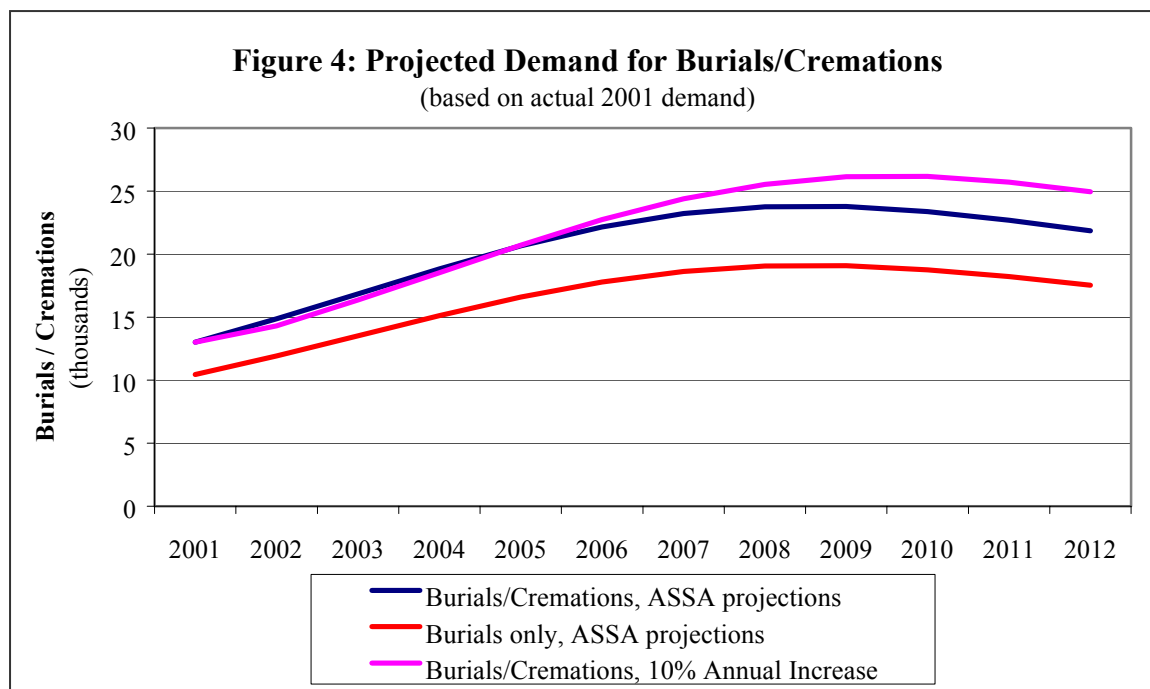
distribution. For instance, there are almost certainly more young adults living in the municipal area than there are people in other age groups, because adults may come to the city to find work while children and older people remain in rural areas. In addition, to interpret this data we would have to know more about the migration patterns of people who are seriously ill; perhaps the elderly are more likely to return to rural areas to die, or to be buried in rural areas, than are younger individuals. One way to reach a better understanding of the effect of HIV/AIDS on the demand for burials and cremations in Durban would be to track the statistics over time. Unfortunately, attempts to obtain retrospective data on metropolitan-area burials as part of this research proved fruitless, but such efforts would be a worthwhile component of future research.

Epidemiological models of the HIV/AIDS epidemic can be used to project the demand for burials and cremations over the next ten years.<sup>24</sup> Using the 2001-2002 burial statistics as a baseline and applying the impact of the AIDS epidemic,<sup>25</sup> the projection shows that the demand for burials and cremations will increase from now until approximately 2009, with a slight downturn to follow (see Figure 4). The predicted annual rate of increase is highest in 2002, at 14.26%, but reaches approximately 0% in 2009 and is negative thereafter. Also shown in Figure 4 is the effect of applying a flat 10% annual rate of increase in demand, as the department currently does in its planning efforts, which results in quite similar usage figures over time as in the more specific AIDS model.

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<sup>24</sup> Epidemiological data was extracted from the ASSA 2000 AIDS and Demographic model of the Actuarial Society of South Africa, using the ASSA KZN provincial workbook, downloaded July 22, 2002 from <http://www.assa.org.za/aidsmodel.asp>. This data was used to calculate the annual increase in total mortality over a baseline of the year July 1, 2001 – June 30, 2002. This was then applied to the total number of burials in Durban in that year, provided by the eThekweni Department of Cemeteries and Crematoria, to calculate the likely number of burials each year from now until 2010. See Appendix A for the actual figures.

<sup>25</sup> Because municipal-level statistics are not available, this projection uses KwaZulu-Natal provincial data, and assumes that the HIV/AIDS epidemic in the eThekweni municipal are mirrors that of the province.



The housing department is also experiencing a substantial demand-side impact from HIV/AIDS, with the epidemic creating new and unique housing problems for the department to meet. For instance, it must grapple with how to meet the unique housing needs of orphans, child-headed households, and the ill or disabled – all groups that are growing rapidly as a direct result of the HIV/AIDS epidemic. The department is engaged in some innovative pilot projects to develop housing solutions for the increasing number of orphans.<sup>26</sup> Based on an estimate that there will be 160 000 orphans in eThekweni by 2010, the department is looking at ways to increase the ‘absorptive capacity’ of settlements and communities – many of which are already reaching their ‘saturation point’ – so that orphaned children are not removed from their communities and placed in institutions. The first of several pilot projects currently underway is the use of transitional housing subsidies to provide extension housing units to crèche workers in Inanda, a community near Durban. The crèche workers had written to the municipality for help after finding themselves taking in students whose parents had passed away. The project aims to relieve the burden on these women in terms of space and resources, and to help them apply for social welfare grants and other forms of assistance. A second project seeks to acquire repossessed houses from banks at no cost and to turn these into homes for orphaned children and ‘house mothers’, all supported through social welfare grants. In many cases these houses cannot easily be re-sold and instead represent a cost to the bank to protect and maintain them. A pilot involving three houses is now in the feasibility stage; if it works well, the

<sup>26</sup> Information on the department’s orphan housing initiatives comes from the interview with Bedford, who is heading this effort.

potential for expansion is considerable, as the banks apparently have hundreds of these repossessed homes on their books.<sup>27</sup> The department is working on a handful of other pilot efforts, trying to find a way to adequately serve the growing pools of orphaned and vulnerable children, while still carrying out its primary services to the general population. It is also aware of a range of related issues, such as how to provide for the transfer of homes and property to children – who are currently not allowed to inherit property except through a formal legal trust – in the case of parents' deaths.

The department's projections and medium- to long-term planning have also been complicated by the epidemic. Based on extensive research on the municipality's informal settlements, completed in 2000, the department's staff was relatively confident that they had a grasp of the scope and scale of the municipality's housing backlog: 554 informal settlements, with 200 000 households and 0.75 million people.<sup>28</sup> The sheer magnitude of the need surprised them – and the council – but at least allowed for careful planning. Now, after several years of start-up, the department is aiming to complete 16 000 houses per year starting in 2002, at which rate it had expected to have the current housing crisis under control within 15 years.

The HIV/AIDS epidemic, however, throws greater uncertainty into these plans. Because they know very little about how HIV/AIDS affects patterns of household formation, and because housing subsidies by law are awarded to households, not to individuals, it becomes very difficult to predict how the epidemic will change the number of households needing housing – even if it were possible to predict with confidence how the epidemic will affect the total number of *people* needing housing, which it is not. If, for instance, the epidemic results in the aggregation of larger groups of people under one roof, this may result in a decrease in the demand for housing. The housing demand within the eThekweni municipality might also be reduced if people infected and affected by HIV/AIDS are more likely to move away from urban areas and to rural areas. If, however, increasing numbers of people flock to the Durban municipal area, or if families splinter and scatter, resulting in more people living in small households, then the demand for housing would be even greater.

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<sup>27</sup> This rough estimate of the number of homes available was provided by Makhathini, not Bedford.

<sup>28</sup> Information about the housing backlog comes from interviews with Makhathini, Bedford, and Byerley.

## Municipal Responses

The eThekweni municipality has thus far failed to implement comprehensive policies and programmes to minimise the impact of HIV/AIDS on its workforce and operations (Wild, 2002; Matthias, 2002; Dr Stanley Naraidu, 2002; and Hermien Kotze, 2002: interviews),<sup>29</sup> although this might be about to change. Plans for a comprehensive city-wide response to HIV/AIDS were ‘in the works’ for more than a year before the eThekweni AIDS Council was finally launched in November 2002.<sup>30</sup> This multi-stakeholder council, which is chaired by the mayor and composed of representatives from government, the private sector, the National Association of People Living with Aids (NAPWA), religious organisations, and a range of other research and civil society institutions, is tasked with co-ordinating the municipality’s response to HIV/AIDS. The council will work closely with the city’s department of health, and will advise the municipal executive committee. According to its ‘Business Plan Framework’, the eThekweni AIDS Council will address the following broad categories: prevention; treatment, care and support; and research, monitoring and evaluation. This framework lists as priorities the establishment of ‘an integrated parallel HIV/TB/STD programme’, the ‘greater and closer involvement of men’, and ‘education’. The first task of the AIDS Council is to expand this framework into a comprehensive business plan, while maintaining and expanding existing programmes around education and awareness, voluntary counselling and testing, and home-based care, implementing mother-to-child transmission (MTCT) programmes, and ‘streamlining’ HIV/AIDS within all municipal departments (eThekweni AIDS Council Business Plan Framework, 2002). This plan suggests that the municipality is headed in the right direction, but there is much still to do before the municipality has effective policies and programmes in place.

Even without a comprehensive city-wide AIDS programme, and often without dedicated resources, several departments have created their own, independent HIV/AIDS interventions. The occupational health department, for instance, has nurses and doctors who go into the field to identify workers who fit the illness profile for AIDS and encourage them to undergo voluntary counselling and testing for HIV. For these and other workers, the department then provides prophylactic treatment for opportunistic infections, information about nutrition

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<sup>29</sup> This information about government inaction is taken from a number of interviews.

<sup>30</sup> Several of the people interviewed said they believed the delay in implementing HIV/AIDS programming at a local level was largely the result of politics, and was specifically linked to political tensions at a national level over President Thabo Mbeki’s views on AIDS and over the ANC’s policies. Others argued the delay was simply a result of not prioritising HIV/AIDS, or considering the epidemic to be “someone else’s problem.” The AIDS Council was launched on November 9, 2002 at the Ocean Conference Centre in Durban.



and ‘wellness’, and some measure of support and assistance to affected employees’ households (Naraidu, 2002: interview). The department of parks, recreation, cemeteries and culture has started a monthly HIV/AIDS forum to discuss issues around HIV/AIDS, with speakers on topics ranging from the medical and legal issues to the experiences of people living with HIV/AIDS. This forum is mandatory for all managers within the department, and representatives from every level and sector of employees must also be present (Matthias, 2002: interview).

The electricity department, which seems to be one of the hardest-hit departments in terms of the impact of HIV/AIDS on personnel, also seems to have one of the best support programmes in place to help manage the impact of HIV/AIDS on individual workers and on the department. According to the electricity department’s human resource staff, every municipal department is supposed to have an Employee Assistance Programme (EAP), but the electricity department’s EAP is significantly more extensive than those in other departments. The programme, run by the human resource office, provides counselling and referral for any number of personal problems, ranging from illness to financial difficulties or divorce, and even includes hospital and home visits. The human resource office employs social workers and welfare officers, as well as trained counsellors, and is (according to the director) the only department to do so. Employees are sometimes referred to the EAP by their managers, but many also access the human resource office’s services on their own initiative. The office also runs some pro-active EAP programming, such as attaching information on HIV/AIDS to employees’ pay slips. The EAP services existed long before AIDS was a major issue, but in the context of AIDS – with high and rising levels of absenteeism, illness and death among workers, their families, and their communities – the programme provides an important service to infected and affected employees. The private, one-to-one counselling process even enables some workers to speak openly about their HIV status, and consequently to seek testing, support services, care and treatment. Programmes such as these can serve as a model for how municipal departments can better serve the needs of their workers and, simultaneously, mitigate the epidemic’s impact on their own operations.

Thus, there are pockets of valuable activity throughout the eThekweni municipality where people are trying to meet the challenges of HIV/AIDS and mitigate the epidemic’s impact. In fact, there are almost certainly more programmes in operation than could be explored during this research. However, even these valuable pockets of activity cannot compensate for the lack of a comprehensive, city-wide programme. If the eThekweni AIDS Council, the elected Metro Council, and the municipality’s top management echelons do not

implement an aggressive, citywide programme, the consequences for governance and service provision could be severe.

## **Recommendations for Future Research**

This research probably generates more questions than answers, and points to a number of valuable avenues for future research. Perhaps the most obvious of these is the question of how HIV/AIDS affects public participation. The researcher is also not much better equipped now than she was when she began to suggest a research method for evaluating the impact of HIV/AIDS on public participation. On a macro level, electoral data could be analysed along with epidemiological information to explore whether the HIV/AIDS epidemic affects voter turnout. At a municipal level, no repositories of relevant data were found that could be used to measure public participation. It seems any further inquiries into this topic, beyond electoral analyses, would require extensive primary research. This research would probably either be survey- or interview-based, and would need to measure participation in some way and then explore any possible relationships, causal or otherwise, between HIV/AIDS and levels of democratic participation.

This researcher had hoped to access human resource data for the entire municipal workforce of more than 20 000, in order to model the current and future impact of HIV/AIDS on personnel. Despite numerous promises that such information was being compiled, however, it never arrived. Future research could collect this sort of data, perhaps for multiple municipalities, and analyse the likely HIV/AIDS rates within the municipal workforces based on factors such as age, gender, and grade of employment. Other human resource data that might be useful for tracking the impact of HIV/AIDS are rates of absenteeism, family responsibility leave, and turnover. This preliminary research revealed that few, if any, departments keep such data in an easily-accessible manner (if at all), even though monitoring the effect of HIV/AIDS on human resources over time and using those findings to inform future planning is one of the best ways to manage the impact of this epidemic. Co-operative efforts between municipalities and researchers could thus benefit both, by helping the former to plan for and mitigate the impact of AIDS and the latter to understand and analyse that impact. If comprehensive management information systems are established now, they could provide baseline and ongoing data as this epidemic progresses.

A comprehensive effort to track demand for government services over time would also be beneficial for both service providers and researchers. The evidence points to a future change in demand for services such as burials and

houses, but it would be valuable to measure whether such a change really occurs, and at what magnitude. The data presented here on burials and cremations, for instance, could be used as a baseline for a longitudinal study. The findings could then be incorporated into planning for this and other municipalities.

Additional research on how the epidemic affects representative bodies could be of particular value to understanding the impact of HIV/AIDS on democracy. In addition to councillor attendance records, information is available on councillor turnover and rates of by-elections. As mentioned earlier, it would also be helpful to compare councillor attendance and turnover data from municipalities with high and low incidences of HIV/AIDS, and to compare the attendance records of councillors who are known to have died of an extended illness with those of healthy councillors. Finally, but perhaps most importantly, it is necessary to explore in a more substantive manner the implications of increased councillor absenteeism and turnover for governing capacity and democracy; in other words, does it really matter if representatives are growing ill and dying in greater numbers because of HIV/AIDS? A related issue is the value of having people living with HIV/AIDS represented on legislative bodies, which may in fact outweigh the drawbacks in terms of absenteeism and turnover.

One area that was essentially ignored during this research was the financial impact of HIV/AIDS, such as on pensions, human resource expenditure, or municipal budgets. Inquiries on these topics could provide valuable insights into the epidemic's effects, insights that could help shape efforts to manage the epidemic. Another neglected but important topic is the actual implications of absenteeism and turnover on productivity. Government institutions are hardly models of efficiency, and it does not necessarily follow that losing personnel – whether temporarily or permanently – will hurt a department's productivity. It is possible that the additional strain will actually force the department to become more efficient and more productive. An in-depth analysis of these dynamics would be valuable in understanding and responding to the impact of HIV/AIDS.

The costs and benefits of providing treatment to HIV-infected employees and their spouses is another very important area for future research. The costs of treatment for HIV/AIDS – including, but not solely, anti-retroviral treatment – have fallen significantly in recent years, and many private-sector companies have deemed it cost-effective to provide such treatment to their employees and their families. In the public sector, the benefits of treatment provision could be even greater: as one of the largest (if not the largest) employers in many areas, a municipality could have a far-reaching impact on the scope of the epidemic in its communities simply by providing treatment to employees. Moreover, by improving the health and extending the lives of HIV-positive employees and

representatives, the municipality will minimise the impact of HIV/AIDS on governing and service-provision capacity, with positive implications for the communities it serves. The same applies to government institutions at provincial and national levels. Further research on the impact of HIV/AIDS on government institutions should be paired with research on the costs and benefits of treatment provision, in order to help those institutions to make informed decisions about the level of care and support to offer to HIV-positive employees.

Finally, there are numerous and potentially worthwhile opportunities for replicating this research. Because of the recent restructuring of local government, the temporal limitations on local-level research are significantly broader at provincial or national levels. It is possible, then, that this research model could be replicated at other levels of government with greater freedom in compiling retrospective data. Comparative research across different levels of government and also among different entities at the same level –among multiple municipalities, for instance, or multiple provinces – would also be quite valuable. Moreover, it might be useful to take this research beyond the borders of South Africa, to find municipalities or other government entities that are grappling with different stages of the epidemic, such as Nairobi or Kampala (advanced, long-standing epidemics) or Lagos (new, rapidly-spreading epidemic).

## **Conclusions**

Preliminary findings confirm that the epidemic will present a unique and serious challenge to institutions of local government, but otherwise raise more questions than answers. As communities grapple with the impact of the epidemic and rely increasingly on providers of basic services, the very institutions that provide such services will themselves face absenteeism, turnover, and financial strain as a result of the epidemic. However, the particular dimensions of the impact on municipal governments are still largely unknown, and more in-depth and comparative research is needed to better understand the nature of the threat to local-level democracy, and to help municipalities adequately plan for and minimise the epidemic's impact.

# **Appendix A: Interview Frameworks**

## **Preliminary Interviews – Framework**

- Details: Name, position, length of time in that position, relationship to Durban Municipal Government (for outside persons)
- Do you see an impact from HIV/AIDS in the work that you do? Elaborate...Is there a response to help mitigate that impact?
- Do you think HIV/AIDS is impacting other parts of the Durban municipal government? In what ways? What makes you think this (evidence, perceptions, etc)?
- How do you think HIV/AIDS might impact your department or council in the future? How might it impact other parts of the municipal government? In general, how might it impact the way the city is managed?
- Do you see people missing work because of AIDS-related illnesses? Because they have family members or friends who are ill or have died as a result of AIDS? How do you know these are AIDS-related – do people speak openly about it?
- Have you seen evidence of turnover among officials or representatives because of HIV/AIDS?
- Have you seen an impact of HIV/AIDS on the municipal budget or the budget for your department or council? Is the epidemic affected expenditure on things like housing and welfare, for instance? Is money being redirected to areas more heavily impacted by HIV/AIDS and thus reducing the budget for other areas? (i.e., is housing getting more money and transportation getting less?
- What is the attitude towards HIV/AIDS within your department/council? In the rest of the municipal government? Is the epidemic perceived to be a major issue (for the department/council and for the Unicity at large)? Do people recognise that AIDS will affect officials and representatives and, therefore, the municipal government structure? Are there problems with stigma? discrimination? denial?
- What is being done about HIV/AIDS within your department/council? Within the municipal government as a whole? Are there HIV/AIDS workplace policies in place? Are there HIV/AIDS interventions in place? Are people talking about HIV/AIDS?

- Are there people living openly with HIV/AIDS in your department/council or elsewhere in the municipality? Are they involved in policy discussions and programmes?

## **Service Provision Departments – Interview Framework**

*Individual details:* Name, position, length of time in that position, type of work (e.g., direct personnel management, strategic direction, financial management)

*Department details:* purpose, activities/areas served, structure of department, how dep't fits within municipal structure, history (e.g., any recent restructuring?)

### **Human Resources**

- Number of employees, (by age, gender, grade, type of work, type of contract)
- Benefits provided: medical aid? pension? funeral benefits?
- Sick leave provision? Compassionate/ family responsibility leave?
- What experience/training is required for different job categories?
- Do some jobs require experience gained on the job?
- How easy is it to replace people in different job categories?
- Are there 'key posts', where a person's loss or absence has a greater impact on the department?
- Are certain employees at greater risk of exposure to HIV? (Such as those who must travel for work or are based away from home?)

### **Management Information System**

- How does the department record absence from work? Lateness for work? People leaving work early?
- Does the department maintain records of reasons for employees' absence?
- Does the department keep records of compassionate leave?
- What are these data used for?
- Where are they collected and collated? By whom? For how long?
- Is it possible to access data on absenteeism / sick leave/ turnover/ deaths over time, preferably by grade, gender, and age? (If so, see more specific list at end)

## **Impact of HIV/AIDS on Human Resources**

General: Do you see an impact of HIV/AIDS on your staff? Elaborate...

**Absenteeism:**

- Have you seen increased levels of illness among your staff (sick leave, medical boarding, etc.)? Do you believe this to be AIDS-related? Why/Why not? Do managers/ staff members consider these illnesses to be AIDS-related? Are any of the staff openly HIV-positive/ disclose that they are sick with AIDS?
- Have you seen an increase in usage of compassionate leave / family responsibility leave? Is any of this potentially AIDS-related: i.e., attending funerals, caring for loved ones, etc.?
- Have you seen an increase in absenteeism overall? If so: Why do you think that is? Any reason to link it to AIDS?
- What is your department's policy on serious illness? What happens when someone becomes very ill, exhausts sick leave, exceeds medical aid allowance, etc.?
- Do you have a specific HIV/AIDS policy?
- How does absenteeism affect operations? Is your department significantly less efficient/effective when people are missing? How easy is it to cover for those individuals? Have you dealt with absenteeism among 'key posts'?

**Turnover:**

- What is your normal level of staff turnover (i.e., do you often lose staff members to other jobs, other departments, or to retirement or medical boarding)?
- Have you seen any increase in turnover? In turnover due to ill health/death, in particular? Do you believe this to be AIDS-related? Why/Why not?
- Does high turnover negatively affect your department? Has it been hard to replace workers? Are there restrictions on replacement hiring? How long are posts vacant before a replacement is found? How costly is recruitment, hiring and training?

**Benefits/ Financial Impact:**

- Have you seen an impact on benefit structures: medical aid, pensions, etc.? Is there increased usage? Financial strain?
- Has your department considered the financial implications of HIV/AIDS for these benefit structures? Have you implemented any policy changes or taken other action to ensure that pensions and other benefits are sustainable in an era of HIV/AIDS?

**Impact of HIV/AIDS on Operations:**

- Is the epidemic changing the type of services that your department provides, or changing how it provides it? (e.g., different types of

housing required) Do you think it might in the future? (*Elaborate: follow-up questions related to type of services*)

- Is the epidemic changing the level of demand for your services? Is it shifting demand from one group or geographic area to another? From one type of service to another?
- Have you seen an impact of HIV/AIDS on the municipal budget or the budget for your department? Is money being redirected to areas more heavily impacted by HIV/AIDS and thus reducing the budget for other areas? (i.e., is health getting more money and transportation getting less?) Is there less money available overall because revenue is decreasing?
- Has your department incorporated HIV/AIDS into strategic planning efforts? Into budgeting?

### **Attitudes/policies towards HIV/AIDS:**

- What is the attitude towards HIV/AIDS within your department? Is the epidemic perceived to be an issue for your department? Are there problems with stigma? discrimination? denial?
- What is the level of knowledge and awareness around HIV/AIDS in your department and among staff members?
- What is being done about HIV/AIDS within or by your department? Are there HIV/AIDS workplace policies in place? Are there HIV/AIDS interventions in place? (Education, behaviour change, VCT, treatment, condoms in the bathroom...) Are people talking about HIV/AIDS?
- Are there people living openly with HIV/AIDS in your department? Are they involved in policy discussions and programmes?

### **Quantitative/ detailed data: if records are available**

**Absenteeism** (please provide information for up to 5 years)

- Rates or numbers of absences per month, by grade, gender, and age
- Rates of short-term and extended absenteeism
- Reasons for absenteeism

**Sick Leave** (please provide information for up to 5 years)

- Absence by grade and age
- Diagnosis
- Number of employees (per month)
- Number of work days lost per month

**Ill-Health Retirements** (please provide information for up to 5 years)

Numbers per month by:



- Age, Grade, Gender, Engagement date, Level of training
- Diagnosis at time of departure – i.e., reason for leaving
- Were any of these key personnel who were difficult to replace?

***Death Data*** (please provide information for up to 5 years)

Numbers per month by:

- Age, Grade, Gender, Engagement date, Level of training
- Cause (diagnosis)
- Were any of these key personnel who were difficult to replace?

***Other/Undefined Turnover*** (please provide information for up to 5 years)

- Numbers of employee departures per month & reasons for departures
- Do departures correlate with absenteeism – do people leave after extended absenteeism?
- Were any of these key personnel who were difficult to replace?

## Appendix B: Burials/Cremations

Projections for municipal-area burials and cremations  
(Based on actual 2001 total burials/cremations: 13015)

YEAR:	2001	2002	2003	2004	2005	2006
Increase in total mortality, over 2001 baseline (KZN - from ASSA 2000))		0.1426	0.2949	0.4474	0.5877	0.7034
Burials/Cremations, projected	13015	14871	16853	18838	20664	22170
Burials only, projected	10447	11937	13528	15121	16587	17795
Annual rate of increase, projected Burials/Cremations		0.1426	0.133292	0.11777	0.096932	0.072873
Burials/Cremations, with flat 10% annual increase	13015	14316.5	16358.03	18538.44	20721.7	22730.31

YEAR:	2007	2008	2009	2010	2011	2012
Increase in total mortality, over 2001 baseline (KZN - from ASSA 2000))	0.7843	0.8253	0.827	0.7962	0.7432	0.6791
Burials/Cremations, projected	23223	23756	23778	23378	22688	21853
Burials only, projected	18641	19069	19087	18765	18211	17542
Annual rate of increase, projected Burials/Cremations	0.047493249	0.0229782	0.000931	-0.016858	-0.029507	-0.036771
Burials/Cremations, with flat 10% annual increase	24386.7261	25544.931	26131.91	26156.25	25715.3	24956.52

### Total:

**Burials/Cremations, projected: 245 087**

**Burials/Cremations, flat 10% annual increase: 258 572**

### NOTE:

The 'projected' figures use epidemiological data extracted from the ASSA 2000 AIDS and Demographic model of the Actuarial Society of South Africa, using the ASSA KZN provincial workbook, downloaded July 22, 2002 from <http://www.assa.org.za/aidsmodel.asp>. This data was used to calculate the annual increase in total mortality in the province over a baseline of the year July 1, 2001 – June 30, 2002. This was then applied to the total number of burials in Durban in that year (13015), provided by the eThekweni Department of Cemeteries and Crematoria, to calculate the likely number of burials each year from now until 2010. The projected number of burials and cremations based on an assumed 10% annual increase is included for comparative purposes, as this is the figure the department currently uses for planning purposes.

## Appendix C: Councillor Attendance

### Applications for Leave:

Date Submitted	# Granted Leave	# Listed "Indisposed"	Indisposition as Proportion of Total Leave	Notes
2/26/01	6	0	0.00%	no reasons listed for leave applies
3/26/01	21	0	0.00%	no reasons listed for leave applies
5/2/01	17	0	0.00%	no reasons listed for leave applies
5/28/01	16	0	0.00%	no reasons listed for leave applies
6/29/01	15	0	0.00%	no reasons listed for leave applies
7/30/01	27	1	3.70%	1 indefinite
8/17/01	36	5	13.89%	1 indefinite and 1 "sick"
10/29/01	16	1	6.25%	
11/28/01	17	1	5.88%	
12/13/01	15	1	6.67%	
2/28/02	14	3	21.43%	
4/22/02	16	1	6.25%	
5/24/02	18	7	38.89%	1
6/10/02	35	6	17.14%	
6/28/02	13	2	15.38%	See note below
7/31/02	16	9	56.25%	
8/26/02	16	3	18.75%	
10/7/02	10	3	30.00%	
10/29/02	18	6	33.33%	

Note: Actually 78 applied for leave, but 65 of these were for 29.6.2002, a Saturday special event. Excluding these is a more accurate comparison to other months.

### Councillor Absences

Date of Meeting	Number Absent	Number Indisposed	Indisposition as % of Absences
2/26/01	5	0	0.00%
3/26/01	8	0	0.00%
5/2/01	15	2	13.33%
5/28/01	16	0	0.00%
6/29/01	9	0	0.00%
7/30/01	22	1	4.55%
8/17/01	38	4	10.53%
10/29/01	10	1	10.00%
11/28/01	16	1	6.25%
12/13/01	19	1	5.26%
2/28/02	14	3	21.43%
4/22/02	8	0	0.00%
5/24/02	27	4	14.81%
6/10/02	16	3	18.75%
6/28/02	10	2	20.00%
7/31/02	18	9	50.00%
8/26/02	11	3	27.27%
10/7/02	3	2	66.67%
10/29/02	10	4	40.00%

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Mark Byerley, Acting Executive Director: Housing Support and Policy, Department of Housing. Interviewed October 24, 2002.

Sipho Cele, Director: Corporate Services. Interviewed September 3, 2002.

Pepe Dass, Acting Manager: Department of Cemeteries and Crematoria. Interviewed October 22, 2002.

Teresa Dominik, Manager: Development, Urban Strategy Department. Interviewed by phone, August 23, 2002.

Hermien Kotze (formerly of the eThekweni Transformation Office): Centre for Civil Society, University of Natal, Durban. Interviewed August 21, 2002.

Maurice Makhathini, Acting Director: Department of Housing. Interviewed October 24, 2002.

Pam Matthias, Director: Human Resources for Department of Parks, Culture and Recreation. Interviewed September 5, 2002.

Linda Mbonambi, Transformation Office. Interviewed August 27, 2002.

Jabulani Rome Mdiniso, Manager: Department of Cemeteries and Crematoria. Interviewed October 22, 2002.

Mpho Mthembu, Director: Community Services, Outer West Local Council. Interviewed September 2, 2002.

Dr. Stanley Naraidu, Director: Occupational Health and Safety. Interviewed September 5, 2002.

Royal Phumlani Ntombela, Director: Department of Cemeteries and Crematoria. Interviewed October 22, 2002.

Ray Sharp, Director: Human Resources, Department of Electricity. Interviewed November 18, 2002.

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## The Centre for Social Science Research

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The CSSR is an umbrella organisation comprising five units:

The Aids and Society Research Unit (ASRU) supports quantitative and qualitative research into the social and economic impact of the HIV pandemic in Southern Africa. Focus areas include: the economics of reducing mother to child transmission of HIV, the impact of HIV on firms and households; and psychological aspects of HIV infection and prevention. ASRU operates an outreach programme in Khayelitsha (the Memory Box Project) which provides training and counselling for HIV positive people

The Data First Resource Unit ('Data First') provides training and resources for research. Its main functions are: 1) to provide access to digital data resources and specialised published material; 2) to facilitate the collection, exchange and use of data sets on a collaborative basis; 3) to provide basic and advanced training in data analysis; 4) the ongoing development of a web site to disseminate data and research output.

The Democracy In Africa Research Unit (DARU) supports students and scholars who conduct systematic research in the following three areas: 1) public opinion and political culture in Africa and its role in democratisation and consolidation; 2) elections and voting in Africa; and 3) the impact of the HIV/AIDS pandemic on democratisation in Southern Africa. DARU has developed close working relationships with projects such as the Afrobarometer (a cross national survey of public opinion in fifteen African countries), the Comparative National Elections Project, and the Health Economics and AIDS Research Unit at the University of Natal.

The Social Surveys Unit (SSU) promotes critical analysis of the methodology, ethics and results of South African social science research. One core activity is the Cape Area Panel Study of young adults in Cape Town. This study follows 4800 young people as they move from school into the labour market and adulthood. The SSU is also planning a survey for 2004 on aspects of social capital, crime, and attitudes toward inequality.

The Southern Africa Labour and Development Research Unit (SALDRU) was established in 1975 as part of the School of Economics and joined the CSSR in 2002. SALDRU conducted the first national household survey in 1993 (the Project for Statistics on Living Standards and Development). More recently, SALDRU ran the Langeberg Integrated Family survey (1999) and the Khayelitsha/Mitchell's Plain Survey (2000). Current projects include research on public works programmes, poverty and inequality.

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